

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-003906

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

2

VS 300
Rev. 4/59

DATE AMENDED

INSTEAD OF

SHOULD READ

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY St Louis, Mo		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY St Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) St Louis, Mo		c. CITY OR TOWN Overland	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St Lukes Hospital		d. STREET ADDRESS (If outside, give location) 9104 Arlene	
3. NAME OF DECEASED (Type or print) First Edward Middle Joseph Last Myers		4. DATE OF DEATH Month 1 Day 1 Year 1963	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9-13-1908
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool & Die Maker		10b. KIND OF BUSINESS OR INDUSTRY Maffitt Tool Co.	
11. BIRTHPLACE (City and state or country) St Louis, Mo		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Frank Myers		13b. MOTHER'S MAIDEN NAME Mary O'Rourke	
14. NAME OF HUSBAND OR WIFE Mary Myers		15. WAS DECEASED EVER IN U.S. ARMED FORCE? (Yes, no, or unknown) (If yes, give war or dates) No	
16. INFORMANT Mary Myers		17. ADDRESS 9104 Arlene Overland 14, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of head, apparently self inflicted in home in Overland, Mo., on or about January 1, 1963 While suffering a temporary mental aberration. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Suicide			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) See above		20c. TIME OF INJURY Hour 1:11 a.m. Month 1 Day 1 Year 1963	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
20f. CITY, TOWN, OR LOCATION Overland, Mo		COUNTY STATE	
21. I attended the deceased from 8:30 A to 8:30 A and last saw her alive on 1-2-63 Death occurred at 8:30 A on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Helen L. Taylor Coroner		22b. ADDRESS 1300 Clark Ave.	
22c. DATE SIGNED 1-2-63		23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
23b. DATE 1-4-1963		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery	
23d. LOCATION (City, town, or county) Florissant, Mo		23e. DATE RECD. BY LOCAL REG. JAN 2 1963	
24. FUNERAL DIRECTOR Ortmann F Home		25. ADDRESS 9222 Lackland	
26. REGISTRAR'S SIGNATURE Boan Smith, M.D.			

USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Al C Ostmann

Licensed Embalmer No. 3478

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license)

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.